

CERTIFICATE OF DEATH

Reg. Dist. No.

06188
166

6196

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Garrett MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland, | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland, | | | |
| c. LENGTH OF STAY IN 1b 41 yrs. | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Mi. S. Oakland, | | | | d. STREET ADDRESS 5 Mi. S. Oakland, | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Nancy Middle L. Last Beachy | | | | 4. DATE OF DEATH Month June Day 20, Year 1956 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 31, 1882 | 9. AGE (In years last birthday) 74 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Eli C. Yoder | | | | 14. MOTHER'S MAIDEN NAME Dora Hostetler | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ---- | | 17. INFORMANT Mrs. Eli D. Beachy Address Oakland, Md. R. D. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Feb 1 , 19 55 , to Jan 20 , 19 56 , that I last saw the deceased alive on Jan 20 , 19 56 , and that death occurred at 9:30 A. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE E. I. Baumgardner M.D. | | | | ADDRESS (Street, City or town, state) 25 Cedar St Oakland Md DATE SIGNED 6/21/56 | | | |
| PHYSICIAN'S NAME (Type) E. I. BAUMGARDNER | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/23/1956 | | 22c. NAME OF CEMETERY OR CREMATORY Slabaugh Cemetery | | 22d. LOCATION (City, town, or county) (State) Md. near Gortner, Garrett Co., | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton | | | | ADDRESS Oakland, Md. | | 24a. REC'D BY REGISTRAR DATE 6/23/56 24b. REGISTRAR'S SIGNATURE John A. Brown | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | |
| John Doe | | Male | | 45 | |
| Date of Death | | Place of Death | | Cause of Death | |
| June 25, 1956 | | Home | | Heart Disease | |
| Time of Death | | Manner of Death | | Occupation | |
| 10:00 AM | | Natural | | Teacher | |
| Signature of Physician | | Signature of Registrar | | Signature of Informant | |
| [Signature] | | [Signature] | | [Signature] | |

BUREAU V. 3

JUN 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06189

6197

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Garrett MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Garrett | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland | | c. LENGTH OF STAY IN 1b 3 Wks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller-rural | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home | | | d. STREET ADDRESS Star route | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Thomas First William Middle Beeman Last | | | 4. DATE OF DEATH June Month 14 Day 19 Year 56 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 19 Nov. 1877 | | 9. AGE (In years last birthday) 78 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner | | 10b. KIND OF BUSINESS OR INDUSTRY Coal Mine | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME George Beeman | | | 14. MOTHER'S MAIDEN NAME Eliza Green | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 00 | | 17. INFORMANT John Beeman-Deerpark, Md. Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Atherosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cerebral hemorrhage (b) (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs 5 mo. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from May 21 , 19 56 to June 14 , 19 56 , that I last saw the deceased alive on June 13 , 19 56 , and that death occurred at 8:30 M., from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE Arthur F. Jones | | M.D. Oakland Md | | DATE SIGNED 6-14-56 | |
| PHYSICIAN'S NAME (Type) Arthur F. Jones | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/17/56 | | 22c. NAME OF CEMETERY OR CREMATORY Turner Cem. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. J. Boal | | ADDRESS Westernport, Md. | | 24a. REC'D BY REGISTRAR 6/17/56 | |
| 24b. REGISTRAR'S SIGNATURE Julius H. Brown | | | | | |

CERTIFICATE OF BIRTH

BUREAU V. 2

JUN 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6198
CERTIFICATE OF DEATH

061906
166

Reg. Dist. No.

| | | | | | | | | | | | | | | | | | |
|---|------|--|------|--|--|---|--|--|--|-----------------|--|------------------|--|--------|------|-------|------|
| 1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GARRETT COUNTY MEMORIAL HOSPITAL</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WEST VIRGINIA</u> b. COUNTY <u>GRANT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BAYARD</u> d. STREET ADDRESS <u>85X-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>HOMER</u> Middle <u>LEONARD</u> Last <u>BONNER</u> | | | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>16</u> Year <u>1956</u> | | | | | | | | | | | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>MAY 8, 1905</u> | | 9. AGE (In years last birthday) <u>51</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>STATE ROAD COMM.</u> | | 11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | | | |
| 13. FATHER'S NAME <u>STEPHEN BONNER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CHRISTINE VARNER BONNER</u> | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. <u>236-14-6856</u> | | | | 17. INFORMANT Address <u>MRS. EVELYN L. BONNER, BAYARD, W. VA.</u> | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> DUE TO <u>Rheumatic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>years</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Respiratory Infection</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | | | | | |
| 21. I certify that I attended the deceased from <u>1951</u> to <u>6/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/15</u> , 19 <u>51</u> , and that death occurred at <u>5:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>6/16/56</u> ACTUAL SIGNATURE <u>Thomas F. Lusby</u> M.D. PHYSICIAN'S NAME (Type) <u>THOMAS F. LUSBY, M.D.</u> <u>5th & OAK STREETS, OAKLAND, MARYLAND</u> | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>JUNE-18-1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>RED HOUSE CEMETERY</u> | | 22d. LOCATION (City, town, or county) <u>NEAR OAKLAND</u> (State) <u>MD.</u> | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Bolden</u> | | | | ADDRESS <u>OAKLAND MD.</u> | | 24a. REC'D BY REGISTRAR DATE <u>6/18/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Julia M. Brown</u> | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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| I, <u>JOHN J. HARRIS</u> , Registrar, do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health. | |
| STATE OF MARYLAND COUNTY OF BALTIMORE CITY OF BALTIMORE | DECEASED <u>JOHN J. HARRIS</u> DATE OF DEATH <u>June 22, 1956</u> PLACE OF DEATH <u>Home</u> CAUSE OF DEATH <u>Heart Disease</u> MANNER OF DEATH <u>Natural</u> |
| SEX <u>Male</u> AGE <u>78</u> BIRTH DATE <u>1878</u> BIRTH PLACE <u>Maryland</u> OCCUPATION <u>Retired</u> MARITAL STATUS <u>Married</u> SPOUSE'S NAME <u>John J. Harris</u> EDUCATION <u>High School</u> RELIGION <u>Catholic</u> RACE <u>White</u> COLOR <u>White</u> BUILD <u>Medium</u> HAIR <u>Gray</u> EYES <u>Blue</u> SKIN <u>Fair</u> TALLNESS <u>5' 8"</u> WEIGHT <u>170</u> BLOOD TYPE <u>A</u> SIGNATURE OF REGISTRAR <u>John J. Harris</u> DATE <u>June 22, 1956</u> PLACE <u>Baltimore, Maryland</u> | SIGNATURE OF PHYSICIAN <u>John J. Harris</u> DATE <u>June 22, 1956</u> PLACE <u>Baltimore, Maryland</u> |

BUREAU V. 3.

JUN 22 1956

RECEIVED

BURIAL
 OAKLAND M.D. 100-10000
 GREENWICH CEMETERY
 BALTIMORE, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13,14 Film 108 6-18-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

06191
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6199

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|---|---------------------------|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | | | c. LENGTH OF STAY IN 1b 3 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | | | d. STREET ADDRESS ROUTE # 1 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ESTON Middle OSCAR Last CARR | | | | 4. DATE OF DEATH Month JUNE Day 2 Year 1956 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/17/86 | | 9. AGE (In years last birthday) 69 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WOODSMAN | | 10b. KIND OF BUSINESS OR INDUSTRY LUMBER | | 11. BIRTHPLACE (State or foreign country) W. VA. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Johnson Carr | | | | 14. MOTHER'S MAIDEN NAME Amanda Carr | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK. | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS. THELMA CARR Address ROUTE # 1 - DEER PARK, MD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Primary Carcinoma of sigmoid Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 18 mos. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 1956, to June 2 1956, that I last saw the deceased alive on June 2 1956, and that death occurred at 8:45 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Joseph Alvarez M.D. | | | | ADDRESS (Street, city or town, state) Oakland, Md DATE SIGNED June 3, 1956 | | | |
| PHYSICIAN'S NAME (Type) JOSEPH ALVAREZ, M.D. | | | | OAKLAND, MARYLAND | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 5, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Roy Cemetery | | 22d. LOCATION (City, town, or county) (State) Dry Fork, W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle ADDRESS Davis, W. | | | | 24a. REC'D BY REGISTRAR DATE 1/5/56 | | 24b. REGISTRAR'S SIGNATURE Julia H. Rowan | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

111

| | | | | | | | | | | | | | | | |
|------------------------|--|-------------------------|--|-----------------|--|-----------------|--|---------------|--|----------------|--|-----------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | 45 | | M | | W | | JAN 15 1880 | | BALTIMORE, MD | | JAN 15 1925 | | BALTIMORE, MD | |
| MARRIAGE | | DATE | | PLACE | | NAME | | DATE | | PLACE | | NAME | | DATE | |
| MARRIED | | JAN 15 1900 | | BALTIMORE, MD | | JAMES H. HARRIS | | JAN 15 1900 | | BALTIMORE, MD | | JAMES H. HARRIS | | JAN 15 1900 | |
| CAUSE OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | | DATE | | PLACE | | NAME | | DATE | |
| HEART DISEASE | | CORONARY ARTERY DISEASE | | ANGINA PECTORIS | | HYPERTENSION | | JAN 15 1925 | | BALTIMORE, MD | | JAMES H. HARRIS | | JAN 15 1925 | |
| MANNER OF DEATH | | NATURAL | | ACCIDENT | | SUICIDE | | DATE | | PLACE | | NAME | | DATE | |
| NATURAL | | JAN 15 1925 | | BALTIMORE, MD | | JAMES H. HARRIS | | JAN 15 1925 | | BALTIMORE, MD | | JAMES H. HARRIS | | JAN 15 1925 | |
| SIGNATURE OF PHYSICIAN | | DATE | | PLACE | | NAME | | DATE | | PLACE | | NAME | | DATE | |
| JAMES H. HARRIS | | JAN 15 1925 | | BALTIMORE, MD | | JAMES H. HARRIS | | JAN 15 1925 | | BALTIMORE, MD | | JAMES H. HARRIS | | JAN 15 1925 | |
| SIGNATURE OF REGISTRAR | | DATE | | PLACE | | NAME | | DATE | | PLACE | | NAME | | DATE | |
| JAMES H. HARRIS | | JAN 15 1925 | | BALTIMORE, MD | | JAMES H. HARRIS | | JAN 15 1925 | | BALTIMORE, MD | | JAMES H. HARRIS | | JAN 15 1925 | |

RECEIVED

BUREAU A. 3

6200

CERTIFICATE OF DEATH

Reg. Dist. No. 166

| | | | | | | | |
|--|-------------------------------|--|---------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE OKLAHOMA b. COUNTY Stephens | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | | | c. LENGTH OF STAY IN 1b 49 hours | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | | | d. STREET ADDRESS 1110 SYCAMORE | | | |
| 3. NAME OF DECEASED (Type or print) First HOWARD Middle WILLIAM Last COLGAN | | | | 4. DATE OF DEATH Month JUNE Day 14 Year 1956 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 10, 1906 | | 9. AGE (In years last birthday) 49 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER | | 10b. KIND OF BUSINESS OR INDUSTRY OIL FIELD SUPPLIES | | 11. BIRTHPLACE (State or foreign country) OHIO | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 13. FATHER'S NAME ABNER JAMES COLGAN | | | | 14. MOTHER'S MAIDEN NAME MILDRED BELLE SLATER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 510-10-9296 | | 17. INFORMANT Viola May Colgan | | Address Duncan, Oklahoma | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute cardiac failure DUE TO (c) Hypertensive cardiovascular disease. INTERVAL BETWEEN ONSET AND DEATH one-half hour 50 hours 3 years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction 1954 | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 12th, 1956, to June 14th, 1956 , that I last saw the deceased alive on June 14th, 1956 , and that death occurred at 7:10 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James H. Feaster, Jr. | | M.D. 58 2nd St. Oakland, Md. | | ADDRESS (Street, city or town, state) 58 2nd St. Oakland, Md. | | DATE SIGNED June 14th | |
| PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M. D. | | 58 2nd. ST., OAKLAND, MD. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 6/15/1956 | | 22c. NAME OF CEMETERY OR CREMATORY Via Air Transportation to Duncan, Oklahoma. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Lighton | | ADDRESS Oakland, Md. | | 24a. REC'D BY REGISTRAR June 15/56 | | 24b. REGISTRAR'S SIGNATURE James H. Feaster, Jr. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|------------------------------------|--|-------------------------------|--|---------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. CAUSE OF DEATH | |
| 10. PLACE OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF WITNESSES | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF CLERK | | 15. SIGNATURE OF JUDGE | |
| 16. SIGNATURE OF SHERIFF | | 17. SIGNATURE OF CORONER | | 18. SIGNATURE OF JURY | |
| 19. SIGNATURE OF DISTRICT ATTORNEY | | 20. SIGNATURE OF COUNTY CLERK | | 21. SIGNATURE OF TOWNSHIP CLERK | |
| 22. SIGNATURE OF VILLAGE CLERK | | 23. SIGNATURE OF CITY CLERK | | 24. SIGNATURE OF STATE CLERK | |
| 25. SIGNATURE OF FEDERAL CLERK | | 26. SIGNATURE OF MARSHAL | | 27. SIGNATURE OF SHERIFF | |
| 28. SIGNATURE OF JUDGE | | 29. SIGNATURE OF CLERK | | 30. SIGNATURE OF JURY | |
| 31. SIGNATURE OF DISTRICT ATTORNEY | | 32. SIGNATURE OF COUNTY CLERK | | 33. SIGNATURE OF TOWNSHIP CLERK | |
| 34. SIGNATURE OF VILLAGE CLERK | | 35. SIGNATURE OF CITY CLERK | | 36. SIGNATURE OF STATE CLERK | |
| 37. SIGNATURE OF FEDERAL CLERK | | 38. SIGNATURE OF MARSHAL | | 39. SIGNATURE OF SHERIFF | |
| 40. SIGNATURE OF JUDGE | | 41. SIGNATURE OF CLERK | | 42. SIGNATURE OF JURY | |
| 43. SIGNATURE OF DISTRICT ATTORNEY | | 44. SIGNATURE OF COUNTY CLERK | | 45. SIGNATURE OF TOWNSHIP CLERK | |
| 46. SIGNATURE OF VILLAGE CLERK | | 47. SIGNATURE OF CITY CLERK | | 48. SIGNATURE OF STATE CLERK | |
| 49. SIGNATURE OF FEDERAL CLERK | | 50. SIGNATURE OF MARSHAL | | 51. SIGNATURE OF SHERIFF | |
| 52. SIGNATURE OF JUDGE | | 53. SIGNATURE OF CLERK | | 54. SIGNATURE OF JURY | |
| 55. SIGNATURE OF DISTRICT ATTORNEY | | 56. SIGNATURE OF COUNTY CLERK | | 57. SIGNATURE OF TOWNSHIP CLERK | |
| 58. SIGNATURE OF VILLAGE CLERK | | 59. SIGNATURE OF CITY CLERK | | 60. SIGNATURE OF STATE CLERK | |
| 61. SIGNATURE OF FEDERAL CLERK | | 62. SIGNATURE OF MARSHAL | | 63. SIGNATURE OF SHERIFF | |
| 64. SIGNATURE OF JUDGE | | 65. SIGNATURE OF CLERK | | 66. SIGNATURE OF JURY | |
| 67. SIGNATURE OF DISTRICT ATTORNEY | | 68. SIGNATURE OF COUNTY CLERK | | 69. SIGNATURE OF TOWNSHIP CLERK | |
| 70. SIGNATURE OF VILLAGE CLERK | | 71. SIGNATURE OF CITY CLERK | | 72. SIGNATURE OF STATE CLERK | |
| 73. SIGNATURE OF FEDERAL CLERK | | 74. SIGNATURE OF MARSHAL | | 75. SIGNATURE OF SHERIFF | |
| 76. SIGNATURE OF JUDGE | | 77. SIGNATURE OF CLERK | | 78. SIGNATURE OF JURY | |
| 79. SIGNATURE OF DISTRICT ATTORNEY | | 80. SIGNATURE OF COUNTY CLERK | | 81. SIGNATURE OF TOWNSHIP CLERK | |
| 82. SIGNATURE OF VILLAGE CLERK | | 83. SIGNATURE OF CITY CLERK | | 84. SIGNATURE OF STATE CLERK | |
| 85. SIGNATURE OF FEDERAL CLERK | | 86. SIGNATURE OF MARSHAL | | 87. SIGNATURE OF SHERIFF | |
| 88. SIGNATURE OF JUDGE | | 89. SIGNATURE OF CLERK | | 90. SIGNATURE OF JURY | |
| 91. SIGNATURE OF DISTRICT ATTORNEY | | 92. SIGNATURE OF COUNTY CLERK | | 93. SIGNATURE OF TOWNSHIP CLERK | |
| 94. SIGNATURE OF VILLAGE CLERK | | 95. SIGNATURE OF CITY CLERK | | 96. SIGNATURE OF STATE CLERK | |
| 97. SIGNATURE OF FEDERAL CLERK | | 98. SIGNATURE OF MARSHAL | | 99. SIGNATURE OF SHERIFF | |
| 100. SIGNATURE OF JUDGE | | 101. SIGNATURE OF CLERK | | 102. SIGNATURE OF JURY | |

BUREAU V. E.

JUN 20 1956

RECEIVED

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy shall be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

6201 **CERTIFICATE OF DEATH**

Reg. Dist. No. 172

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY GARRETT | STATE MARYLAND | COUNTY GARRETT | |
| CITY (If outside corporate limits, write RURAL OR KITZMILLER) | LENGTH OF STAY 45 yrs | CITY (If outside corporate limits, write RURAL and give nearest town) OR KITZMILLER | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS E. MAIN STREET | | STREET ADDRESS (If rural give location) CHURCH STREET | |
| 3. NAME OF DECEASED (First) BERTHA (Middle) ELLEN (Last) DAVIS | | 4. DATE OF DEATH (Month) JUNE (Day) 2 (Year) 56 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED | 8. DATE OF BIRTH OCT. 17, 1882 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | 9. AGE last birthday 73 yrs. 11. BIRTHPLACE (State or foreign country) Cross, Mineral Co., W. Va. |
| 13. FATHER'S NAME HENRY LEWIS SIMON | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 14. MOTHER'S MAIDEN NAME MARGARET ELLEN SMITH | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT & ADDRESS Mrs. Louise Banning, Kitzmiller, Md. | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | 18. MEDICAL CERTIFICATION |
| 442X IMMEDIATE CAUSE (A) Acute Myocardial Infarction | | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| ANTECEDENT CAUSE(S) DUE TO (B) Coronary Vascular Disease | | | 6 hrs |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan 1956, to June 2, 1956, that I last saw the deceased alive on June 2, 1956, and that death occurred at 9:50 PM, from the causes and on the date stated above. | | | |
| SIGNATURE Ralph Coleman Dreller | | ADDRESS (Street, city, town, state) Kitzmiller, Md. | |
| DATE June 4-56 | | DATE SIGNED June 4-56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 6/5/56 | NAME OF CEMETERY OR CREMATORY Nethken Hill Cemetery | LOCATION (City, town, or county) (State) Elk Garden, W. Va. |
| 24. RECEIVED BY REGISTRAR June 4-56 | REGISTRAR'S SIGNATURE AW Barrick | 25. FUNERAL DIRECTOR'S SIGNATURE Orthodox Charles | |
| | | ADDRESS Blaine, W. Va. | |

CERTIFICATE OF DEATH

NAME OF DECEASED: **JOHN J. BROWN**
 SEX: **MALE** AGE: **45**
 PLACE OF BIRTH: **NEW YORK**
 OCCUPATION: **SALES**
 MARITAL STATUS: **MARRIED**
 DATE OF DEATH: **NOV. 15, 1955**
 PLACE OF DEATH: **HOME**
 CAUSE OF DEATH: **HEART DISEASE**
 MEDICAL ATTENDANCE: **DR. J. H. SMITH**
 SIGNATURE OF PHYSICIAN: **J. H. SMITH**
 SIGNATURE OF DECEASED: **JOHN J. BROWN**

DATE OF BIRTH: **NOV. 15, 1910**
 PLACE OF BIRTH: **NEW YORK**
 OCCUPATION: **SALES**
 MARITAL STATUS: **MARRIED**
 DATE OF DEATH: **NOV. 15, 1955**
 PLACE OF DEATH: **HOME**
 CAUSE OF DEATH: **HEART DISEASE**
 MEDICAL ATTENDANCE: **DR. J. H. SMITH**
 SIGNATURE OF PHYSICIAN: **J. H. SMITH**
 SIGNATURE OF DECEASED: **JOHN J. BROWN**

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 PLACE OF BIRTH: **NEW YORK**
 OCCUPATION: **SALES**
 MARITAL STATUS: **MARRIED**
 DATE OF DEATH: **NOV. 15, 1955**
 PLACE OF DEATH: **HOME**
 CAUSE OF DEATH: **HEART DISEASE**
 MEDICAL ATTENDANCE: **DR. J. H. SMITH**
 SIGNATURE OF PHYSICIAN: **J. H. SMITH**
 SIGNATURE OF DECEASED: **JOHN J. BROWN**

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 PLACE OF BIRTH: **NEW YORK**
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 MARITAL STATUS: **MARRIED**
 DATE OF DEATH: **NOV. 15, 1955**
 PLACE OF DEATH: **HOME**
 CAUSE OF DEATH: **HEART DISEASE**
 MEDICAL ATTENDANCE: **DR. J. H. SMITH**
 SIGNATURE OF PHYSICIAN: **J. H. SMITH**
 SIGNATURE OF DECEASED: **JOHN J. BROWN**

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 PLACE OF BIRTH: **NEW YORK**
 OCCUPATION: **SALES**
 MARITAL STATUS: **MARRIED**
 DATE OF DEATH: **NOV. 15, 1955**
 PLACE OF DEATH: **HOME**
 CAUSE OF DEATH: **HEART DISEASE**
 MEDICAL ATTENDANCE: **DR. J. H. SMITH**
 SIGNATURE OF PHYSICIAN: **J. H. SMITH**
 SIGNATURE OF DECEASED: **JOHN J. BROWN**

DATE OF BIRTH: **NOV. 15, 1910**
 PLACE OF BIRTH: **NEW YORK**
 OCCUPATION: **SALES**
 MARITAL STATUS: **MARRIED**
 DATE OF DEATH: **NOV. 15, 1955**
 PLACE OF DEATH: **HOME**
 CAUSE OF DEATH: **HEART DISEASE**
 MEDICAL ATTENDANCE: **DR. J. H. SMITH**
 SIGNATURE OF PHYSICIAN: **J. H. SMITH**
 SIGNATURE OF DECEASED: **JOHN J. BROWN**

BUREAU V. 2

DN 5 1955

RECEIVED

DECEASED

622

CERTIFICATE OF DEATH

Reg. Dist. No. 166

| | | | |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | d. STREET ADDRESS 141 Second Street | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle WESLEY Last DAVIS | | 4. DATE OF DEATH Month JUNE Day 2 Year 1956 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-24-76 |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John M. Davis | | 14. MOTHER'S MAIDEN NAME Philson, Eleanor | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Wife Mrs. Sarah Ruth Davis, 141 2nd St. | | Address Oakland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, terminal 350x DUE TO (b) Parkinson's Disease DUE TO (c) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years 10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1956 , to 2 June , 19 56 , that I last saw the deceased alive on 2 June , 19 56 , and that death occurred at 10:05 AM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 3 June 56 | |
| ACTUAL SIGNATURE Andrew E. Mance M.D. | | PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D. Oakland, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/5/1956 | 22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery | 22d. LOCATION (City, town, or county) (State) Oakland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton ADDRESS Oakland, Md. | | 24a. REC'D BY REGISTRAR DATE 6/5/1956 | 24b. REGISTRAR'S SIGNATURE Julia A. Brown |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12-5

| | | | |
|--|--|--|--|
| <p>1. NAME OF DECEASED <i>John J. Smith</i></p> | | <p>2. SEX <i>Male</i></p> | |
| <p>3. AGE <i>45</i></p> | | <p>4. DATE OF BIRTH <i>Jan 15, 1900</i></p> | |
| <p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p> | | <p>6. OCCUPATION <i>Engineer</i></p> | |
| <p>7. CAUSE OF DEATH <i>Heart Disease</i></p> | | <p>8. MANNER OF DEATH <i>Natural</i></p> | |
| <p>9. DATE OF DEATH <i>June 2, 1956</i></p> | | <p>10. TIME OF DEATH <i>10:30 AM</i></p> | |
| <p>11. PLACE OF DEATH <i>Home</i></p> | | <p>12. SIGNATURE OF PHYSICIAN <i>John J. Smith</i></p> | |
| <p>13. SIGNATURE OF REGISTRAR <i>John J. Smith</i></p> | | <p>14. SIGNATURE OF WITNESSES <i>John J. Smith</i></p> | |

BUREAU V. 2

JUN 2 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06195

6203

CERTIFICATE OF DEATH

Reg. Dist. No. 161

1. PLACE OF DEATH:

County GarretteCity or town Friendsville Rural West
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 89 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County GarretteCity or town Friendsville West
(If outside city or town limits, write RURAL and give nearest town)Street No. West
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Frazee

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Bessie Detrick7. Birth date of deceased (mo., day, yr.) May 16 1867

6. (c) If alive, give age years

8. AGE: Years 89 y4 Months Days It less than one day
hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Jermiah Frazee12. Name Maryland13. Birthplace Hallie Boyer14. Maiden name Maryland

15. Birthplace

16. Informant FriendsvilleAddress Burial17. Date thereof June 26 1956
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory SandspringLocation E.G.Harned18. Funeral director Brandonville W. VaAddress Brandonville W. Va19. June 27 1956
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1956, at21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 54 to June 24 1956and that I last saw him alive on June 22 1956Immediate cause of death Chronic myocarditisDue to ArteriosclerosisOther conditions 4.2.1

Major findings of operations

Date of op.

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Melvin Jaffer MDAddress Friendsville Ind Date signed June 25, 1956

Mal

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RECEIVED
JUN 27 1956
BUREAU Y. A.

CERTIFICATE OF DEATH

Reg. Dist. No. 166

| | | | | | | | |
|--|------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | | | c. LENGTH OF STAY IN 1b 1 3/4 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSVILLE | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First LOUDICA Middle Last FRIEND | | | | 4. DATE OF DEATH Month JUNE Day 24 Year 19 56 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUGUST 15, 1871 | | 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME ISAAC FRIEND | | | | 14. MOTHER'S MAIDEN NAME JULIA CASTEEL | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS. HOWARD SKIDMORE | | Address FRIENDSVILLE, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic, Cerebro-vascular disease DUE TO (c) disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 21 June, 1956 , to 24 June, 1956 , that I last saw the deceased alive on 24 June, 1956 , and that death occurred at 5:15 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Andrew E. Mance | | | | ADDRESS (Street, city or town, state) Oakland Md | | | |
| PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D. | | | | DATE SIGNED 25 June 56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/27/56 | | 22c. NAME OF CEMETERY OR CREMATORY Friendsville | | 22d. LOCATION (City, town, or county) (State) Friendsville Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jack A. Friend | | | | ADDRESS Friendsville | | 24a. REC'D BY REGISTRAR DATE 6/25/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Howard | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6205

CERTIFICATE OF DEATH

Reg. Dist. No. 166

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Garrett MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Eglon, W. Va. b. COUNTY Preston | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland | | c. LENGTH OF STAY IN 1b 1 year | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Week's Nursing Home, Oakland, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eglon, W. Va. | |
| 3. NAME OF DECEASED (Type or print) First John Howard Middle Hanline Last 4. DATE OF DEATH Month June Day 12th Year 1956 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 28, 1883 |
| 9. AGE (In years last birthday) 73 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Aurora, W.Va. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jacob Hanline | | 14. MOTHER'S MAIDEN NAME Belle Knotts | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Goldie White | | Address Eglon, W.Va. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 4 days Years Years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 P. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 1954 , 19____, to June 11th , 19 56 , that I last saw the deceased alive on June 11th , 19 56 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 58 2nd St. Oakland, Md. 6.12.56 | | | |
| ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> | | M.D. 58 2nd St. Oakland, Md. | |
| PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M. D. | | 58 2nd St., Oakland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 6/15, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY Stemple Ridge | | 22d. LOCATION (City, town, or county) (State) Aurora, W.Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne C. Spiggle</i> | | ADDRESS Davis, W.Va. | |
| 24a. REC'D BY REGISTRAR 6/13/56 | | 24b. REGISTRAR'S SIGNATURE <i>John A. Rowan</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6206

CERTIFICATE OF DEATH

Reg. Dist. No.

166

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Garrett MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, | | | | c. LENGTH OF STAY IN 1b 1 day | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gorman | | | | d. STREET ADDRESS 2 Mi. North | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First George Middle Wilson Last Harvey | | | | 4. DATE OF DEATH Month June Day 20 , Year 1956 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 13, 1876 | |
| 9. AGE (In years last birthday) yrs. 79 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Benjamin F. Harvey | | | | 14. MOTHER'S MAIDEN NAME Christina Stilley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Wayne Harvey | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STARVATION 420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENETIC INFLUENCE (c) AVUSIAN DISASSIMILATION | | | | INTERVAL BETWEEN ONSET AND DEATH 2 YEARS 4 YEARS 7 YEARS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ULcers, Multiple, Intake, Lungs, Arteriosclerotic | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Garrett County, Md. | | | | (County) (State) | | | |
| 21. I certify that I attended the deceased from 11/21, 1949 , to 6-19, 1956 , that I last saw the deceased alive on 6-19, 1956 , and that death occurred at 2:15 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James H. Feaster, Jr. | | | | ADDRESS (Street, city or town, state) 58 2nd St. Oak Hill, Md. | | | |
| PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D. | | | | DATE 58 2ND. ST., OAKLAND, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 6/23/1956 | | 22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery | |
| 22d. LOCATION (City, town, or county) Garrett County, Md. | | | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton | | | | ADDRESS Oakland, Md. | | 24a. REC'D BY REGISTRAR 6/23/56 | |
| 24b. REGISTRAR'S SIGNATURE John H. Brown | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------------|--|-------------------------|--|--------------------------|--|-------------------|--|---------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES H. HARRIS | | 45 | | M | | W | | JAN 1900 | | BALTIMORE, MD. | |
| MARRIAGE | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | NAME OF SPOUSE | | DATE OF DEATH | | PLACE OF DEATH | |
| MARRIED | | JAN 1920 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JUN 1956 | | BALTIMORE, MD. | |
| OCCUPATION | | DATE OF OCCUPATION | | PLACE OF OCCUPATION | | NAME OF EMPLOYER | | DATE OF DEATH | | PLACE OF DEATH | |
| LABORER | | JAN 1920 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JUN 1956 | | BALTIMORE, MD. | |
| CAUSE OF DEATH | | DATE OF CAUSE OF DEATH | | PLACE OF CAUSE OF DEATH | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| HEART DISEASE | | JUN 1956 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JUN 1956 | | BALTIMORE, MD. | |
| MANNER OF DEATH | | DATE OF MANNER OF DEATH | | PLACE OF MANNER OF DEATH | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| NATURAL | | JUN 1956 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JUN 1956 | | BALTIMORE, MD. | |
| SIGNATURE OF PHYSICIAN | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | | NAME OF PHYSICIAN | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | JUN 1956 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JUN 1956 | | BALTIMORE, MD. | |
| SIGNATURE OF REGISTRAR | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | | NAME OF REGISTRAR | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | JUN 1956 | | BALTIMORE, MD. | | JAMES H. HARRIS | | JUN 1956 | | BALTIMORE, MD. | |

BUREAU V. 2

JUN 25 1956

RECEIVED

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

061996

6207

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Barrett</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution) Residence before admission) o. STATE <u>Penn</u> b. COUNTY <u>Layette</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> | | c. LENGTH OF STAY IN 1b <u>17 mos</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cuppert Nursing Home</u> | | d. STREET ADDRESS <u>75x-3</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>JESSE G</u> Middle <u>LARAWAY</u> Last <u>LARAWAY</u> | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 16, 1874</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Penn</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John M. Laraway</u> | | 14. MOTHER'S MAIDEN NAME <u>Rebecca Ruth</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>100-100000000</u> | |
| 17. INFORMANT <u>Russell Laraway</u> Address <u>Connellsville Pa</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> <u>422.1</u> DUE TO <u>Art. C. V. D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u></u> (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility + Congestive failure</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1-31</u> , 19 <u>56</u> , to <u>6-4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-31</u> , 19 <u>56</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Thomas J. Luby</u> M.D. | | ADDRESS (Street, city or town, state) <u>77 OAK ST</u> DATE SIGNED <u>6-4-56</u> | |
| PHYSICIAN'S NAME (Type) <u>T. F. LUBY M.D.</u> | | <u>OAKLAND, MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/17/1956</u> | | 22b. NAME OF CEMETERY OR CREMATORY <u>Johns Trade Cem</u> | |
| 22c. LOCATION (City, town, or county) (State) <u>Connellsville Pa</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Bolden</u> ADDRESS <u>Oakland, Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>6/4/56</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>J. W. Brown</u> | | | |

CERTIFICATE OF DEATH

1956

RECEIVED
JUN 8 1956
BUREAU VI 81

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6208

CERTIFICATE OF DEATH

Reg. Dist. No. 06280

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | | | c. LENGTH OF STAY IN 1b 82 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First OLIVER Middle SCOTT Last MOON | | | | 4. DATE OF DEATH Month JUNE Day 8, Year 19 56. | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MAY 4, 1874 | |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | | IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____ | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME GARRETT MOON | | | |
| 14. MOTHER'S MAIDEN NAME JANE WILSON | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. ----- | | | | 17. INFORMANT Address O.S. MOON, OAKLAND, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Gangrene Rt Foot DUE TO Diabetes Mellitus (b) Art. C. V. D. DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from Apr 8, 1956 to June 8, 1956 that I last saw the deceased alive on June 7, 1956 and that death occurred at 6:15 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Thomas D. Lushy M.D. | | | | ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 6/8/56 | | | |
| PHYSICIAN'S NAME (Type) T.F. LUSBY | | | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | |
| 22b. DATE THEREOF 6/10/1956 | | | | 22c. NAME OF CEMETERY OR CREMATORY Thos. Moon Cemetery | | | |
| 22d. LOCATION (City, town, or county) (State) Garrett County, Md | | | | 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herbert C. Leighton Oakland, Md. | | | |
| 24a. RECEIVED BY REGISTRAR DATE 6/10/56 | | | | 24b. REGISTRAR'S SIGNATURE Julia H. Royan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

111

| | | | |
|---|--|---|--|
| <p>1. NAME OF DECEASED [Handwritten: <i>James T. B. ...</i>]</p> | | <p>2. SEX [Handwritten: <i>Male</i>]</p> | |
| <p>3. AGE [Handwritten: <i>45</i>]</p> | | <p>4. DATE OF DEATH [Handwritten: <i>June 13, 1956</i>]</p> | |
| <p>5. PLACE OF DEATH [Handwritten: <i>Home</i>]</p> | | <p>6. CAUSE OF DEATH [Handwritten: <i>Heart Disease</i>]</p> | |
| <p>7. MANNER OF DEATH [Handwritten: <i>Natural</i>]</p> | | <p>8. SIGNATURE OF PHYSICIAN [Handwritten: <i>...</i>]</p> | |
| <p>9. SIGNATURE OF REGISTRAR [Handwritten: <i>...</i>]</p> | | <p>10. SIGNATURE OF WITNESS [Handwritten: <i>...</i>]</p> | |

BUREAU V. 2

JUN 13 1956

RECEIVED

6/14/56 [Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6299 CERTIFICATE OF DEATH

Reg. Dist. No.

06208

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Garrett MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Preston | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingwood. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Callie Evans Rest Home | | d. STREET ADDRESS 85x-3 | |
| 3. NAME OF DECEASED (Type or print) First Hattie Middle Clark Last Murdock | | 4. DATE OF DEATH Month June, 3, Day 19 Year 56 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 18, 1870 |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR Months 3 Days 13 | IF UNDER 24 HRS. Hours 13 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Ironton Ohio, | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John D. Murdock | | 14. MOTHER'S MAIDEN NAME Sarah Bowen | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT John C. Murdock, Kingwood, W.VA. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 537x DUE TO Acute Septic Pyemia (Inch 2) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Feb. 29, 1956 , to June 3, 1956 , that I last saw the deceased alive on June 3, 1956 , and that death occurred at 4:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE E. L. Baumgartner M.D. Alder St. Oakland, Maryland. PHYSICIAN'S NAME (Type) E. L. BAUMGARTNER 22a. BURIAL (Entombment, removal) (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

| | | | | | |
|-----------------------------------|--|-----------------------------|--|--------------------------------|--|
| NAME OF DECEASED John H. Harbo | | SEX Male | | DATE OF BIRTH Jan. 12, 1870 | |
| PLACE OF BIRTH Baltimore, Md. | | OCCUPATION Clerk | | RESIDENCE 1200 N. ... | |
| CAUSE OF DEATH ... | | PLACE OF DEATH ... | | TIME OF DEATH ... | |
| SIGNATURE OF PHYSICIAN ... | | SIGNATURE OF CORONER ... | | SIGNATURE OF | |
| DATE ... | | TIME ... | | PLACE ... | |

RECEIVED

JUN 8 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07234

6210 CERTIFICATE OF DEATH

Reg. Dist. No. 166

| | | | | | | | |
|---|-------------------------------|--|-------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Garrett</u> | | STATE <u>Md</u> | | COUNTY <u>Allegany</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Int. Lake Park</u> | | LENGTH OF STAY (in this place) <u>3 yrs</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kiser Nursing Home</u> | | | | STREET ADDRESS (If rural give location) <u>Rt 5 Cumberland, Md.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Charles Willis O'Brien</u> | | | | 4. DATE OF DEATH (Month) <u>June</u> (Day) <u>30</u> (Year) <u>19 56</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u> | 8. DATE OF BIRTH <u>Feb 27 1870</u> | 9. AGE last birthday <u>86</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u> | | 11. BIRTHPLACE (State or foreign country) <u>Near Bloomington W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John O'Brien</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Libens</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT'S ADDRESS <u>Rosa Evans - 477 Sunset Mt. Cumberland</u> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) <u>450.0</u> | | | | <u>Generalized Atherosclerosis</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | <u>malnutrition</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>March</u> , 19 <u>54</u> , to <u>June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>56</u> , and that death occurred at <u>3:15 P.</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Ed. Baumgartner</u> | | | | DATE SIGNED <u>6/30/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>July 2, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Abe Cemetery</u> | | LOCATION (City, town, or county) <u>Old Furnace W. Va.</u> | |
| 24. REC'D BY REGISTRAR <u>July 2/56</u> | | REGISTRAR'S SIGNATURE <u>Julius Rowan</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Staker</u> | | ADDRESS <u>Cumberland, Md.</u> | |

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

REG. DIST. NO.

DATE OF DEATH

Name of Deceased: *John O'Brien*
 Sex: *Male* Race: *White*
 Date of Birth: *March 27, 1870* Age: *86*
 Usual Residence: *100 West 11th St. New York City*
 Place of Birth: *County Wick, Ireland*
 Cause of Death: *Heart Failure*
 Date of Death: *June 30, 1956*
 Signature: *John O'Brien*
 Address: *100 West 11th St. New York City*

BUREAU V. 2

JUL 19 1956

RECEIVED

JUL 3 1956
 GARRETT COUNTY
 HEALTH DEPT.

RECEIVED

John F. O'Brien
 100 West 11th St. New York City

06202
166

6211

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Garrett MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gormanian, W. Va. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gormanian, W. Va. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Helen Last REPETSKY | | 4. DATE OF DEATH Month June Day 12 Year 1956 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 31, 1883 |
| 9. AGE (In years (by birthday) yrs. 73 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Lithuania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Adam Satkiok | | 14. MOTHER'S MAIDEN NAME Mary (unknown) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Cleteus Corbin, Gormanian, W. Va. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease 422.1 DUE TO with incompetent valves heart Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. 262X (c) Diabetes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes INTERVAL BETWEEN ONSET AND DEATH years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9 Feb 1956 to 12 June 1956 , that I last saw the deceased alive on Feb 18 , 19 56 , and that death occurred at 11:20 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Thomas F. Lusby M.D. | | ADDRESS (Street, city or town, state) OAKLAND, M.D. DATE SIGNED 6/13/56 | |
| PHYSICIAN'S NAME (Type) THOMAS F. LUSBY M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/16/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Catholic Cem. | | 22d. LOCATION (City, town, or county) (State) Thomas, West Va | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. T. Duncan | | ADDRESS Thomas, West Va. | |
| 24a. RECEIVED BY REGISTRAR 6/13/56 | | 24b. REGISTRAR'S SIGNATURE John H. Boyer | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

111

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1955

| | | | |
|--------------------------|--|--------------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| JAMES H. HARRIS | | JAN 20 1955 | |
| AGE | | SEX | |
| 65 | | M | |
| RACE | | EDUCATION | |
| W | | H | |
| OCCUPATION | | CAUSE OF DEATH | |
| Carpenter | | Heart Disease | |
| PLACE OF DEATH | | MANNER OF DEATH | |
| Home | | Natural | |
| RESIDENCE | | CITY | |
| 1234 Main St. | | Baltimore | |
| COUNTY | | STATE | |
| Baltimore | | MD | |
| DATE OF BIRTH | | PLACE OF BIRTH | |
| JAN 1 1890 | | Baltimore | |
| FATHER'S NAME | | MOTHER'S NAME | |
| John H. Harris | | Mary E. Harris | |
| FATHER'S OCCUPATION | | MOTHER'S OCCUPATION | |
| Carpenter | | Homemaker | |
| FATHER'S PLACE OF BIRTH | | MOTHER'S PLACE OF BIRTH | |
| Baltimore | | Baltimore | |
| FATHER'S DATE OF BIRTH | | MOTHER'S DATE OF BIRTH | |
| JAN 1 1860 | | JAN 1 1865 | |
| FATHER'S PLACE OF DEATH | | MOTHER'S PLACE OF DEATH | |
| Baltimore | | Baltimore | |
| FATHER'S CAUSE OF DEATH | | MOTHER'S CAUSE OF DEATH | |
| Heart Disease | | Heart Disease | |
| FATHER'S MANNER OF DEATH | | MOTHER'S MANNER OF DEATH | |
| Natural | | Natural | |
| FATHER'S RESIDENCE | | MOTHER'S RESIDENCE | |
| 1234 Main St. | | 1234 Main St. | |
| COUNTY | | STATE | |
| Baltimore | | MD | |
| DATE OF BIRTH | | PLACE OF BIRTH | |
| JAN 1 1890 | | Baltimore | |
| FATHER'S NAME | | MOTHER'S NAME | |
| John H. Harris | | Mary E. Harris | |
| FATHER'S OCCUPATION | | MOTHER'S OCCUPATION | |
| Carpenter | | Homemaker | |
| FATHER'S PLACE OF BIRTH | | MOTHER'S PLACE OF BIRTH | |
| Baltimore | | Baltimore | |
| FATHER'S DATE OF BIRTH | | MOTHER'S DATE OF BIRTH | |
| JAN 1 1860 | | JAN 1 1865 | |
| FATHER'S PLACE OF DEATH | | MOTHER'S PLACE OF DEATH | |
| Baltimore | | Baltimore | |
| FATHER'S CAUSE OF DEATH | | MOTHER'S CAUSE OF DEATH | |
| Heart Disease | | Heart Disease | |
| FATHER'S MANNER OF DEATH | | MOTHER'S MANNER OF DEATH | |
| Natural | | Natural | |
| FATHER'S RESIDENCE | | MOTHER'S RESIDENCE | |
| 1234 Main St. | | 1234 Main St. | |
| COUNTY | | STATE | |
| Baltimore | | MD | |

BUREAU V. 5

JUN 20 1955

RECEIVED

6/20/55 J. H. Harris

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6212 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06203

Reg. Dist. No.

166

Item 7, Film GL90 6-18-56 87

| | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Barrett</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland-</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>En Route to Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ALLEGANY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTERNPORT</u> d. STREET ADDRESS <u>ROSS ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>WILLIAM JOSEPH ROSS</u> First Middle Last | | | | 4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1956</u> | | | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-19-38</u> | | 9. AGE (In years last birthday) <u>17</u> yrs. | | IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> | | IF UNDER 24 HRS. Hours <u>17</u> Min. <u>17</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HIGH SCHOOL</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>WESTERNPORT MD U. S. A.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME <u>EDWIN ROSS</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>FRANCIS M. BARRICK</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. <u>215-36-8814</u> | | | | 17. INFORMANT <u>EDWIN ROSS</u> Address <u>WESTERNPORT, MD.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: — IMMEDIATE CAUSE (a) <u>Interior Skull Fracture</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushed Rt. Chest</u> DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>70 MINS.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Collision on State Route 495</u> | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>6-8-56</u> Hour <u>2:30</u> p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway near Swanton, Barr, Md</u> | | | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Thomas F. Lusby</u> M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>6-8-56</u> | | | | | |
| EXAMINER'S NAME (Type) <u>THOMAS F. LUSBY</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 22b. DATE THEREOF <u>6-11-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>PHILOS</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>WESTERNPORT M. D.</u> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Bolden Oakland Md</u> | | | | | | 24a. REC'D BY REGISTRAR <u>6/9/56</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Julius A. Rayner</u> | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FilmG200 7-16-56 et Two for One

STATEMENT
EDWIN ROSS
FRANCIS M. BARRICK
HIS SCHOOL WESTERNPORT, D. C.
EDWIN ROSS WESTERNPORT

BUREAU V. 3

JUN 13 1956

RECEIVED

PHOTO

6-11-56

6/12/56
JUN 13 1956
WESTERNPORT

6213

CERTIFICATE OF DEATH

Reg. Dist. No. 766

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Garrett MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland | | c. LENGTH OF STAY IN 1b 6 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville | |
| 3. NAME OF DECEASED (Type or print) First Marie Middle Lydia Last Schroyer | | 4. DATE OF DEATH Month June Day 24 , Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 29, 1903 |
| 9. AGE (In years last birthday) 53 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none - Invalid all | | 10b. KIND OF BUSINESS OR INDUSTRY of adult life | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas J. Schroyer | | 14. MOTHER'S MAIDEN NAME Minnie Mae Ringer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. --- | |
| 17. INFORMANT Earl Schroyer | | Address Friendsville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Muscular dystrophy 744.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH 40 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1, 1956 to June 24, 1956 , that I last saw the deceased alive on June 19, 1956 , and that death occurred at 11:00 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Arthur F. Jones | | ADDRESS (Street, city or town, state) Oakland, Md. | |
| PHYSICIAN'S NAME (Type) Arthur F. Jones | | DATE SIGNED 6/25/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/26/1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery Near Friendsville | | (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton | | ADDRESS Oakland, Md. | |
| 24a. REC'D BY REGISTRAR DATE 6/26/56 | | 24b. REGISTRAR'S SIGNATURE Julia Brown | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06205
Reg. Dist. No. 166

6214

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>G arrett</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN 1b <u>1 hour</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Mem. Hosp.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Allegheny</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Turtle Creek</u> d. STREET ADDRESS <u>821 Elizabeth Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry (NMN) Sleightholm</u> | | | | 4. DATE OF DEATH Month Day Year <u>June 8 1956</u> | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 5, 1878</u> | | 9. AGE (In years last birthday) <u>78</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Factory Foreman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Webbing House Elec. Factory</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Oldham, England</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Richard Sleightholm</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Morris</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>169 10 5705</u> | | | | 17. INFORMANT Address <u>Mrs. Amy Sleightholm, As above</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Coronary</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Infirmity of Age</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u> | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . <u>at 11:55 PM</u> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Thomas F. Lusby</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| EXAMINER'S NAME (Type) <u>Thomas F. Lusby M.D.</u> <u>Acting</u> | | | | | | DATE SIGNED <u>6-9-56</u> | | | | | | | |
| 22a. MANNER OF REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>6/12/1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Churchill Cemetery</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>Wilkins Township, Penna.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Leighton</u> | | | | | | ADDRESS <u>Oakland, Md.</u> | | 24a. REC'D BY REGISTRAR <u>6/9/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>John A. Poyner</u> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.

BUREAU V. E.

JUN 13 1956

RECEIVED

6215

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Allegheny</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabland</u> | | c. LENGTH OF STAY IN 1b <u>April 2, 1956</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cuppitt Nursing Home</u> | | d. STREET ADDRESS <u>414 Park St</u> | |
| 3. NAME OF DECEASED (Type or print) <u>ada</u> First <u>Elizabeth</u> Middle <u>Smeltzer</u> Last | | 4. DATE OF DEATH <u>June 5</u> 19 <u>56</u> Month Day Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar 17, 1891</u> 63 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hotels & Restaurants</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Knott</u> | | 14. MOTHER'S MAIDEN NAME <u>Clara Houch</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>214-12-8397A</u> | |
| 17. INFORMANT <u>Mrs Ruby West</u> Address <u>414 Park St</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June 4</u> , 19 <u>56</u> , to <u>June 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>56</u> , and that death occurred at <u>7:06 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Arthur F. Jones</u> | | DATE SIGNED <u>6-6-56</u> | |
| PHYSICIAN'S NAME (Type) <u>Arthur F. Jones.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6/5/1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Pleasant Valley, Pa.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u> | | 24. REC'D BY REGISTRAR <u>John B. Royer</u> DATE <u>6/6/56</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

NAME OF DECEASED: [Faint text]

DATE OF DEATH: [Faint text]

PLACE OF DEATH: [Faint text]

CAUSE OF DEATH: [Faint text]

DATE OF BIRTH: [Faint text]

PLACE OF BIRTH: [Faint text]

SEX: [Faint text]

RACE: [Faint text]

EDUCATION: [Faint text]

OCCUPATION: [Faint text]

RELIGION: [Faint text]

DATE OF DEATH: [Faint text]

PLACE OF DEATH: [Faint text]

CAUSE OF DEATH: [Faint text]

DATE OF BIRTH: [Faint text]

PLACE OF BIRTH: [Faint text]

SEX: [Faint text]

RACE: [Faint text]

EDUCATION: [Faint text]

OCCUPATION: [Faint text]

RELIGION: [Faint text]

DATE OF DEATH: [Faint text]

PLACE OF DEATH: [Faint text]

CAUSE OF DEATH: [Faint text]

DATE OF BIRTH: [Faint text]

PLACE OF BIRTH: [Faint text]

SEX: [Faint text]

RACE: [Faint text]

EDUCATION: [Faint text]

OCCUPATION: [Faint text]

RELIGION: [Faint text]

BUREAU V. 8

1956 JUN 7

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06207

Reg. Dist. No. 172

| | | | |
|---|-------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garr.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swanton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swanton - Rural</u> | |
| c. LENGTH OF STAY IN 1b <u>Life</u> | | d. STREET ADDRESS <u>Route 1 - Walnut Bottom</u> | |
| e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home - Route 1</u> | | e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES | |
| 3. NAME OF DECEASED (Type or print) <u>TICHINELL SAMUEL PAUGH TICHINELL</u> | | 4. DATE OF DEATH <u>June 14 1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 30/55</u> |
| 9. AGE (in years last birthday) <u>11</u> yrs. | | IF UNDER 1 YEAR <u>11</u> Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Swanton, Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Leo Seidel Tichinell</u> | | 14. MOTHER'S MAIDEN NAME <u>Hagar Dagmar Weese</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Leo Tichinell</u> | | Address <u>Swanton Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Pneumonia</u> DUE TO (b) <u>Measles</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>36 hours?</u> <u>7 June 56</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Thomas F. Lusby</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>THOMAS F. LUSBY MD</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>June 14/56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>6/16/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Turner Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>R#1, Swanton, Garrett Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Oct Sharpless</u> | | ADDRESS <u>Blaine, W. Va.</u> | |
| 24a. REC'D BY REGISTRAR <u>6/14/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>C. W. Barrick</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 18 1956

RECEIVED

062186

6217

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Garrett MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, | |
| c. LENGTH OF STAY IN 1b 60 yrs. | | d. STREET ADDRESS ----- | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Stewart Last Wilson | | 4. DATE OF DEATH Month June Day 11, Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 1, 1876 |
| 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Elijah Stewart | | 14. MOTHER'S MAIDEN NAME Margaret Champ | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. --- | |
| 17. INFORMANT John M. Wilson | | Address Mt. Lake Park, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arth. C. V. D. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 1956 to 6-8 1956 , that I last saw the deceased alive on 6-8 1956 , and that death occurred at 1:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Thomas D. Gushy M.D. | | | |
| PHYSICIAN'S NAME (Type) THOMAS F. LUSBY OAKLAND, MD. 6-12-56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/13/1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery | | 22d. LOCATION (City, town, or county) (State) Terra Alta, W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton | | ADDRESS Oakland, Md. | |
| 24a. RECEIVED BY REGISTRAR 6/12/56 | | 24b. REGISTRAR'S SIGNATURE Julia A. Rowan | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

